Summary of Testimony of Steven Lutzky, Chief, Office on Disabilities and Aging, Medical Assistance Administration, District of Columbia Department of Health Before the Senate Finance Committee
"State Efforts to Redesign Their Long-Term Care Delivery Systems"
March 27, 2001

My name is Steven Lutzky and I am the Chief of the Office on Disabilities and Aging within the Medical Assistance Administration in the DC Department of Health. My office oversees programs serving older adults, younger adults with physical disabilities, individuals with mental retardation and developmental disabilities, and individual with HIV/AIDS. Prior to joining the DC government, I reviewed model long-term care programs for clients including the Department of Health and Human Services. I also facilitated strategic planning in the area of long-term care for states and private sector organizations.

How states design their delivery systems plays the central role in shaping long-term care in the United States because the majority of people needing paid long-term care services rely on states to fund the services they need. For example, state Medicaid programs funded care for approximately one million of the 1.5 million nursing facility residents in 1999.[1] States have recognized this responsibility and have been taking advantage of increasing flexibility given by the federal government to try to develop cost-effective care delivery systems that better serve our citizens.

States have had the twin concerns of controlling costs, while providing services that meet our citizens' needs. In the past, these concerns have often been at odds. States have resisted expanding services designed to keep people in the community, such as personal care, adult day care, and assisted living, because they feared that these services would be so desirable that demand and costs would escalate dramatically. To quell these concerns, states placed limits on the number of people who could receive these services, the amount they could receive, and tried to keep reimbursement as low as possible.

---

[1] AARP (2000). *Across the States 2000: Profiles of Long-Term Care Systems.* Washington, DC: AARP.

However, states that have lead the way in expanding access to home and community-based services (HCBS), such as Oregon and Washington, have not experienced run away costs. In fact, at least one study suggests that expanding HCBS may produce modest overall savings.[2]

In the District of Columbia, we are adapting best practices we have observed in model states to design a cost-effective system that will not only enhance the lives of some of our most vulnerable citizens, but could help us improve the fabric of our community. These model states have designed their programs to support individuals and families rather than replacing them**.** I would like to briefly describe the key lessons that we have learned.

Maximizing the Likelihood that HCBS will Serve Individuals who would Otherwise be in an Institution

To be cost-effective, a system must maximize the likelihood that HCBS will serve individuals who would otherwise be in an institution. First, the program must ensure that accessing HCBS is as easy as accessing an institution. By the time families and individuals get to the point that they seek out assistance, they are often in a caregiving crisis that must be resolved quickly. Waiting lists that take years and authorization processes that take months act to force institutionalization on individuals who cannot wait for assistance. The District is addressing this issue by following the lead of other HCBS Medicaid waiver programs that do not have wait lists and have sped up their eligibility determination process.

Second, individuals must be directed to services that can provide alternatives to institutions. In the District, we are following the lead of states like Wisconsin by building a Resource Center that will empower consumers to make informed choices about long-term care. The Resource Center will receive mandatory referrals from all major pathways to institutionalization (e.g., applicants to nursing facilities, home health agencies, hospitals, etc.).

[2] Alecxih, L.M.B., Lutzky, S., and Corea, J. (1996). *Estimated Cost Savings From the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States*. Washington, D.C.: American Association of Retired Persons, Public Policy Institute.

The Resource Center then offers individual counseling about options for receiving long-term care and will quickly determine eligibility for publicly-funded programs. The Resource Center can save money by (1) diverting individuals not eligible for Medicaid to less expensive settings (e.g., from nursing facility to assisted living or their own home) thereby delaying their spending down to Medicaid eligibility and (2) placing individuals eligible for Medicaid in the most cost-effective setting appropriate to their needs.

Ensuring that HCBS is Cost-Effective

Once the District increases access to HCBS, it must design reimbursement and create infrastructure so that services are provided in a cost-effective manner and quality is carefully monitored. Other states experience suggests that to achieve this goal, the District must increase both flexibility and the ability to carefully monitor costs and quality. The District is working to achieve this goal by: (1) incorporating managed care principles; (2) broadening the range of HCBS services to add more flexible and potentially cost-saving services; (3) implementing information technology that will facilitate the delivery of care and monitoring cost and quality; and (4) adopting outcome-based measures of quality.

Incorporating managed care principles. Current financing for HCBS in most states contains very crude cost-control mechanisms that create the incentive to maximize covered services regardless of whether they best meet the needs of an individual. Managed care payment mechanisms, such as capitated payments or other incentives for providing care cost-effectively, can act to move the decisions about how care is made from the state closer to the actual delivery of care. The goal of adopting managed care mechanisms is to shift the decision of how best to use limited resources from a distant state representative to care managers and the individual and his or her family. The District is carefully watching the experience of demonstrations, such as Texas Star+Plus, Minnesota Senior Health Options, and the Wisconsin Partnership and Family Care programs to determine which reimbursement structure makes sense for the District. Issues

to be decided include which services will be included, to what extent risk will be shared among providers and the District, and which community organizations in the District will assume risk.

Broadening the range of HCBS services to add more flexible and potentially cost-saving services. The increased flexibility offered by managed care payment arrangements must be accompanied by a corresponding increase in the flexibility of services that are offered. In the District, we are working to broaden HCBS available by creating financing for new services, such as consumer-directed attendant care and assisted living facilities. The District currently only offers personal care offered through an agency. This type of care, while appropriate for some, may be costly because of the agencies' administrative costs and other requirements, such as mandating that a visit must be a minimum of four hours. The District is looking to follow the lead of other states, such as Washington, and offer direct payments to individuals. For example, an individual with paraplegia may require assistance for a brief period of time in the morning, noon, afternoon and before bedtime. The District may have to pay for up to sixteen hours of care to induce an agency with a four-hour mandatory minimum to provide services. Under an attendant care program, the District could pay a neighbor who has been trained to provide care for only four hours and with lower administrative costs.

Residential alternatives to nursing facilities, such as assisted living facilities have been key to other states' efforts to reduce the use of nursing facilities. States like Oregon and Washington have demonstrated that these services can improve quality of life, while controlling costs.

Implementing information technology that will facilitate the delivery of care and monitoring cost and quality. The District recognizes that offering capitated payments and increasing flexibility also increases opportunity for providers to limit or provide low quality services. Therefore, we are building infrastructure necessary to more carefully monitor costs and quality. The District has included funds in its 2002 budget to develop a long-term care information technology system. Newly available internet-based technology can help improve the

quality of care, as well as the ability to monitor and control costs and meet necessary federal reporting requirements. This system will be vital to providing case managers with the flexibility to provide services in cost-effective ways, while providing the District with the ability to continually monitor cost and quality. Providers in Texas, Arizona, and Connecticut are currently using these systems.

Adopting outcome-based measures of quality. The District is also planning on adopting outcome-based measures of quality. Monitoring quality in HCBS requires vastly different tools than those used for institutional providers. Licensing mechanisms that the District currently uses add significantly to the cost of care and often impair quality of life. Under the redesigned system, the District would join other states that assess outcome-based measures of quality. The District hopes to improve the ability of this effort to affect quality by tying these outcomes directly to reimbursement.

I would like to take the remaining time that I have to first thank Congress and the federal government for the freedom and support necessary to develop these new programs. 1915(c) HCBS waivers, enhanced matches and other provisions have played a crucial role in transforming long-term care delivery systems. These programs have allowed individuals who felt helpless to feel in control over their destiny. They have made individuals and their families stronger.

I have been very encouraged by what I have seen thus far from the Bush Administration. The District plans on taking advantage of the opportunities offered under the President's New Freedom Initiative. Secretary Thompson of the Department of Health and Human Services understands what states are trying to achieve. In fact, many of the aspects of the District's proposed redesign are based on programs initiated under then Governor Thompson's watch in Wisconsin.

I would like to briefly mention some barriers that must be overcome in the years ahead. First, states need more latitude in blending Medicare dollars with Medicaid dollars. Many individuals in the populations we serve are eligible for both programs, and it is difficult to create

financial incentives for coordination if we can only influence one funding stream. Second, we need the Health Care Financing Administration (HCFA) to view the states as partners. If a state is doing something innovative or there are concerns regarding quality, consider having HCFA detail someone to work with the state rather relying on the often endless process of requests for additional information. Third, consider mechanisms that will allow us to broaden the population we serve. Current requirements for HCBS waivers make it difficult to intervene earlier and prevent individuals with predisposing conditions from progressing to more severe and costly disabilities.

Thank you very much for allowing me to have the opportunity to testify.